Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005017	A. BUILDING _____ B. WING _____	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART GENERAL HOSPITAL	600 E BLVD ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of' one hospital licensure complaint. Complaint Number: IN00089676 Unsubstantiated: Lack of Sufficient Evidence Date: 8/16/11 to 8/17/11 Facility Number: 005017 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Elkhart General Hospital is in compliance with 410 IAC 15-1.5-4, Medical Staff, and 410 IAC 15-1.5-6, Nursing Service, Indiana Hospital Licensure Rules. QA: claughlin 08/23/11	S 000		